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Issue Date: 03 December 2002

CASE NO.: 2002-BLA-152

In the matter of

HERMAN D. KNIGHT,
Claimant,

v.

PEABODY COAL COMPANY,
Employer,

and

OLD REPUBLIC INSURANCE COMPANY,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party-in-Interest.

ORDER AND DECISION - DENYING BENEFITS

This matter involves a claim filed by Mr. Herman D. Knight ("Claimant" or "Mr. Knight") for benefits under the Black Lung Benefits Act, 30 U.S.C. §§901, *et seq.* ("Act"). Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

I conducted a formal hearing in Madisonville, Kentucky, on August 8, 2002, attended by Mr. Knight, Mr. Joseph H. Kelly, counsel for Claimant, and Mr. Philip J. Reverman, Jr., counsel for Peabody Coal Company and Old Republic Insurance Company (collectively "Employer" or "Peabody"). The District Director elected not to attend. My decision in this case is based on the testimony presented at the hearing and all documents admitted into evidence (DX1-29, CX1-3)[1].

[1]The following notations appear in this decision to identify specific evidence: DX - Director's exhibit; CX - Claimant's exhibit, and, TR - Transcript of hearing.

ISSUES

1. Length of coal mine employment.

2. Pneumoconiosis.

3. Causal relationship of pneumoconiosis.

4. Total disability.

5. Causal relationship of total disability.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulation of Fact

At the formal hearing, the parties stipulated that Claimant had at least 5 years of qualifying coal mine employment (TR8).

Coal Miner's Background

Mr. Knight was born on February 4, 1951, and is presently 51 years of age (TR15, DX1). He is married, and has four children, three of whom reside at home with him and his wife (TR16, DX8, DX9, DX10, DX11). His first employment in coal mining was sometime in the 1960's with White Brothers where he ran a bull dozer and drove a coal truck (TR18-19, DX4). Thereafter, he drove a coal truck for United Dock Service, Inc. from 1970 through 1976, and worked at various jobs for Peabody Coal Company from 1977 through 1982 (TR20-23, DX4). Mr. Knight's work with White Brothers and United Dock Service involved hauling unprocessed coal out of a strip mine to another location at which the coal was processed (TR20-21). While employed by Peabody Coal Company, Claimant drove a shuttle car and did various other jobs, all of which were performed underground (TR23). He was laid off by Peabody in 1982 and has not worked in or around any coal mine since (TR26). All of Claimant's coal mine work has been performed in Kentucky.[2]

Procedural Background

Claimant filed an original claim for benefits on October 18, 1999 (DX1). His claim was denied on February 2, 2000 (DX14), and he thereafter requested a formal hearing before an administrative law judge (DX15). Peabody Coal Company and Old Republic Insurance Company were notified by the District Director of their potential liability in this matter (DX18), after which

[2]The location where the claimant last engaged in coal mine employment determines which federal Court of Appeals has appellate jurisdiction. *Shupe v. Director, OWCP,* 12 B.L.R. 1-200, 1-202 (1989)(en banc). Therefore, the U. S. Court of Appeals for the Sixth Circuit has jurisdiction in this case.

notice Peabody gave notice of its controversion with respect to any liability in connection with the claim (DX20, DX22). On June 22, 2000, the matter was referred by the District Director for formal hearing (DX27), but remanded on February 23, 2001, pending final resolution of *National Mining Association v. Secretary, Department of Labor*, No. 1:00 CV 03086 (EGS) (DX28-4). On September 7, 2001, Claimant was notified that the preliminary injunction imposed in *National Mining Association* had been lifted and that the District Director had determined that additional evidence submitted following remand did not warrant a change in the earlier decision denying benefits (DX28-2). Claimant again disagreed with the denial of benefits (DX28-1), and the claim was thereafter returned to this office on January 4, 2002 (DX29).

Responsible Operator

Under the regulations, liability for benefits under the Act is assessed against the most recent coal mine operator which meets the requirements set out in 20 C.F.R. §§725.492, 725.493 (1999).[3] To find the responsible operator, I must start with the most recent employer and work backwards in time until I find the first operator that meets the regulatory requirements for responsible operator. *See Cole v. East Kentucky Colleries*, 20 B.L.R. 1-51 (1996). While the regulations establish numerous criteria for the designation of a responsible operator,[4] the relevant requirement for this claim is length of employment. According to 20 C.F.R. §725.493 (a) (1), the necessary length of employment is a cumulative employment period of not less than one year.

At the hearing, counsel for Peabody conceded that Peabody Coal Company was appropriately identified by the District Director as the responsible operator in this case (TR6).[5] Based on Peabody's concession, as well as Claimant's testimony (TR34), and his Social Security earnings statement (DX4), I find Peabody Coal Company meets the regulatory requirements for responsible operator.

Elements of Entitlement

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[3]On December 20, 2000, the Department substantively amended certain regulatory provisions at 20 C.F.R. Parts 718 and 725. *See* Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg 79,920-79-924 (Dec. 20, 2000). The regulations were made effective to all claims pending or filed as of January 19, 2001, with certain exceptions regarding Part 725 regulations. *See* 20 C.F.R. §725.2(c) (2002). For any claim pending as of January 19, 2001, the version of the regulations which was in effect as of April 1, 1999, applies. *Id*. The exceptions expressly include §§725.492 and 725.493. Therefore, since Mr. Knights claim was filed on October 18, 1999 (DX1), the 1999 version of §§725.492 and 725.493 are applicable. Other Part 725 regulations cited in this decision are similarly designated as either 1999 or 2002 depending on whether such regulations fall within the exceptions specified in §725.2(c).

[4]See 20 C.F.R. §§725.491 - 725.493 (1999).

[5]On August 7, 2000, counsel for Peabody also wrote to the Associate Regional Solicitor for the Department of Labor and "admitted" that Peabody Coal Company was the responsible operator for Mr. Knight's claim (DX28-125). However, this issue was still noted as "contested"on the Form CM-1025 when the case was referred to the Office of Administrative Law Judges (DX29).

Under the Act, a claimant must prove several facts by a preponderance of the evidence to receive benefits. First, the coal miner must establish the presence of pneumoconiosis. In the regulations, "pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment. The definition further includes "any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[6] Under the Act, the legal definition of pneumoconiosis is much broader than "medical pneumoconiosis." *See e.g. Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000)(emphasizing distinction between legal and medical pneumoconiosis and stating miner's exposure to coal dust must merely contribute "at least in part" to his pneumoconiosis). Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[7] If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that pneumoconiosis arose out of such employment.[8] Otherwise, the claimant must provide competent evidence to establish the relationship between pneumoconiosis and coal mine employment.[9] Third, the coal miner must demonstrate total disability.[10] Fourth, the coal miner must prove the total disability is due to pneumoconiosis.[11]

Presence of Pneumoconiosis

According to 20 C.F.R. §718.202 (2002), the existence of pneumoconiosis may be established by four methods: chest x-ray (§718.202 (a)(1)), autopsy or biopsy report (§718.202 (a)(2)), regulatory presumption (§718.202 (a)(3))[12], or physician's opinion based on sound medical judgment (§718.202 (a)(4)). Because the record does not contain any evidence of complicated pneumoconiosis and Mr. Knight applied for Federal Black Lung disability benefits after January 1, 1982, the regulatory presumption of pneumoconiosis is not applicable. In addition, the official record does not contain an autopsy report or a biopsy report. As a result, Claimant must rely on chest x-ray or

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[6]20 C.F.R. §718.201 (2002).

[7]20 C.F.R. §718.203 (a) (2002).

[8]20 C.F.R. §718.203 (b) (2002).

[9]20 C.F.R. §718.203 (c) (2002).

[10]20 C.F.R. §718.204 (b) (2002).

[11]20 C.F.R. §718.204 (a) (2002).

[12]If any of the following presumptions are applicable, then under 20 C.F.R. §718.202 (a)(3) (2002) a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. §718.304 (2002) (if complicated pneumoconiosis is present then there is an irrebuttable presumption the miner is totally disabled due to pneumoconiosis); 20 C.F.R. §718.305 (2002) (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. §718.306 (a) (2002) (presumption when a survivor files a claim prior to June 30, 1982).

medical opinion evidence to establish the existence of pneumoconiosis.

Chest X-ray Evidence

The following table summarizes the interpretations of the x-rays in the record.

Date of x-ray	Exhibit	Physician	Interpretation
11/12/99	DX12	Simpao	1/0[13, 14]
11/12/99	DX12	Westmoreland	No pneumoconiosis[15]
11/12/99	DX13	Sargent, BCR, B[16]	No pneumoconiosis
11/12/99	DX28-124	Wiot, BCR, B	No pneumoconiosis
8/23/00	DX28-120	O'Bryan	0/1

[13]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Similarly, a reading of 0/0 means the doctor found no opacities and did not see any marks that would cause him or her to seriously consider category 1.

[14]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

[15]Dr. Westmoreland is a staff Radiologist at Muhlenberg Community Hospital where Dr. Simpao examined Mr. Knight, and, pursuant to hospital policy, reported his interpretation of Claimant's November 12, 1999, x-ray (DX24-7). His report lists chronic obstructive pulmonary disease ("COPD") and subsegmental atelectatic change bilaterally but does not mention pneumoconiosis (DX12).

[16]The abbreviations "BCR" and "B" used in this table stand for "Board-certified Radiologist" and "B-reader" respectively. A designation of "Board-certified" means that the physician is "certified" in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. A "B-reader" (also known as the "final" reader) is a physician, but not necessarily a radiologist, who has successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH).

8/23/00	DX28-100	Wiot, BCR, B	No pneumoconiosis
4/16/01	CX2[17]	Brandon, BCR, B	1/0
4/25/02	CX3	Brandon, BCR, B	1/0

A review of the radiographic interpretation evidence reveals a conflict in opinion as to whether Mr. Knight suffers from coal workers' pneumoconiosis. In such cases, numerous guidelines exist for evaluating the diverse interpretations. First, the actual number of interpretations favorable and unfavorable may be a factor. *Wilt v. Wolverine Mining Company*, 14 B.L.R. 1-70 (1990). At the same time, mechanical reliance on numerical superiority is not appropriate. *See Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993) ("[a]dministrative fact finders simply cannot consider the quantity of evidence alone, without reference to a difference in the qualifications of the readers or without an examination of the party affiliation of the experts."). Second, consideration may be given to the evaluating physicians' qualifications and training. *Dixon v. North Camp Coal*, 8 B.L.R. 1-344 (1985) and *Melink v. Consolidation Coal Company*, 16 B.L.R. 1-31 (1991). The interpretations from the doctors with the greater expertise may be accorded more evidentiary weight. *Taylor v. Director, OWCP*, 10 BRBS 449, BRB No. 77-610 BLA (1979). The qualifications of the doctor who provided the most recent evaluation may also bear on the evidentiary weight of the study. *McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988). Finally, when faced with multiple interpretations of numerous x-rays, an administrative law judge should first evaluate the conflicting interpretations of one x-ray to determine whether that particular x-ray is negative or positive. Then, the administrative law judge resolves the conflict between the x-rays in context to determine whether pneumoconiosis is present.

There are, as noted above, four chest x-rays contained in this record. The November 12, 1999, x-ray has been interpreted by four different physicians, three of whom, Drs. Westmoreland, Sargent, and Wiot, read the x-ray as negative for pneumoconiosis, and one of whom, Dr. Simpao, read the x-ray as positive for pneumoconiosis. Both Drs. Sargent and Wiot are Board-certified B-readers and are thus more qualified to interpret x-rays than Dr. Simpao. I therefore accord greater weight to the opinions of Drs. Sargent and Wiot and conclude that the November 12, 1999, x-ray, standing alone, does not support a diagnosis of pneumoconiosis. The August 23, 2000, chest x-ray was interpreted as 0/1 by Dr. O'Bryan, and negative for pneumoconiosis by Dr. Wiot. Neither

[17]CX2 and CX3, the two most recent x-rays interpretations contained in the record, were admitted by me over the objections of Peabody at the time of the hearing in Madisonville, Kentucky on August 8, 2002 (TR12). Pursuant to the 20-day rule set forth at 20 C.F.R. §725.456(b)(1) (1999), these reports had been previously provided by Claimant to Peabody on July 12, 2002 (CX2, CX3, TR10). Although counsel for Peabody claimed that he had no opportunity to have those x-rays reviewed prior to the hearing, he candidly admitted that he made no attempt to obtain them for review after learning of their existence on July 12th (TR10). Counsel for Mr. Knight noted that these x-ray reports "were discoverable at any time should counsel have wished to have done that. No attempt was made. No interrogatories were sent. No other discovery was attempted." (TR11). A medical report submitted more than twenty days prior to the hearing does not violate the 20-day rule. *Amorose v. Director, OWCP*, 7 B.L.R. 1-899 (1985).

interpretation supports a diagnosis of pneumoconiosis, and I therefore conclude that this x-ray, standing alone, also does not support Mr. Knight's claim for benefits. Finally, the April 16, 2001, and April 25, 2002, chest x-rays have been interpreted by only one physician, Dr. Brandon, who concluded that both x-rays were consistent with pneumoconiosis. The profusion of opacities noted by Dr. Brandon in both instances was "1/0." As explained previously, this indicates that Dr. Brandon ultimately concluded that small opacities were definitely present but few in number, although he seriously considered finding these two x-rays revealed no small opacities, or so few small opacities that they did not reach a level consistent with category 1.

Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record, especially where a significant amount of time separates newer evidence from that which is older. *Woodward v. Director, OWCP, supra*; *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). The Board has indicated that a seven month time period between x-ray studies is sufficient to apply the "later evidence" rule, but that five and one-half months is too short a time period. *Tokarcik v. Consolidated Coal Co.*, 6 B.L.R. 1-666 (1983); *Stanley v. Director, OWCP*, 7 B.L.R. 1-386 (1984). However, in *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985), the Board held that it was proper for the administrative law judge not to apply the "later evidence" rule where eight months separated the dates of the x-ray studies.

In this case, the two most recent x-rays post-date an earlier negative x-ray by approximately eight and eighteen months, respectively. The only readings of these two x-rays were performed by Dr. Brandon, a Board-certified Radiologist who is also qualified as a B-reader. In recognition of the fact that pneumoconiosis is a progressive and irreversible disease, these two positive x-rays outweigh the earlier negative x-rays described above. I therefore find that the x-ray evidence viewed as a whole tends to support a finding of pneumoconiosis. However, as further explained below, there is substantial medical opinion evidence contained in this record which is contrary to such a finding.

Medical Opinion Evidence

Valentino S. Simpao, M.D.

At the request of the Director, Dr. Valentino S. Simpao conducted a physical examination of Claimant on November 12, 1999 (DX12). In a report dated that same day, Dr. Simpao noted 12 years coal mining employment and a medical history of frequent colds, pneumonia, pleurisy, attacks of wheezing, chronic bronchitis, bronchial asthma, heart disease, allergies, and high blood pressure. He further reported prior hospitalizations which included treatment for a myocardial infarction and blood clots in the legs in 1986, and removal of a blood clot from the left femoral artery in 1996. Dr. Simpao's report reflects a history of smoking one pack of cigarettes per day since 1989 but further notes that Claimant allegedly reduced his tobacco use to two or three cigarettes per day since his

myocardial infarction.[18] Based on his examination, as well as the results of a chest x-ray, a pulmonary function test, and an arterial blood gas study, Dr. Simpao concluded that Claimant suffers from category 1/0 coal workers' pneumoconiosis which results in moderate respiratory impairment. With respect to the etiology of this condition, Dr. Simpao wrote that "multiple years of coal dust exposure is medically significant in his pulmonary impairment."

Dr. Simpao was deposed on January 20, 2000, by Peabody in connection with Mr. Knight's claim (DX24). With regard to his earlier opinion that the November 11, 1999, chest x-ray revealed category 1/0 pneumoconiosis, Dr. Simpao stated that his diagnosis was based on observations of fibronodular densities in the middle and lower zones of the right lung and the middle zone of the left lung (DX24-10). He also testified that signs consistent with pneumoconiosis are generally first seen in the upper lung fields, and he saw no such signs in Mr. Knight's chest x-ray (DX24-11). According to Dr. Simpao, if his reading of the November 11, 1999, chest x-ray had been negative, he might not have diagnosed pneumoconiosis (DX24-13).

Frank H. Taylor, M.D.

In a one-page, two-paragraph letter dated April 24, 2000, Dr. Frank H. Taylor, Claimant's treating physician, expressed the opinion that Mr. Knight suffers from obstructive lung disease, chronic obstructive pulmonary disease, and asthma, and previously experienced problems associated with a pulmonary embolus, a myocardial infarction, and peripheral vascular disease (DX26). Dr. Taylor also wrote that Claimant's "exposure to coal mine dust for thirteen years in a susceptible individual is enough to aggravate an existing lung disease and I believe this happened with Mr. Knight."

Dr. Taylor was deposed by Peabody on September 21, 2000, with respect to Mr. Knight's claim (DX28-45-72). He is a graduate of the University of Tennessee Medical School and Board-certified in both internal medicine and pulmonary diseases (DX28-49). According to Dr. Taylor, he began treating Mr. Knight on June 2, 1985, when Claimant was hospitalized for pneumonia (DX28-53). He has treated Claimant since 1990 in connection with chronic obstructive pulmonary disease, blood clots in his legs and lungs, and anxiety (DX28-51-53). Dr. Taylor testified that the main reason for his treatment of Claimant over the years has been his respiratory disorder. He further stated that cigarette smoking, which Claimant has engaged in for his entire adult life, was a major cause of Mr. Knight's obstructive lung disease (DX28-54-55). According to Dr. Taylor, Claimant has been advised on many occasions to stop smoking cigarettes, which he believes to be at least one pack per day, and Mr. Knight "developed COPD as a result of his persistent cigarette smoking" (DX28-56). It was Dr. Taylor's opinion that an individual can develop chronic bronchitis from cigarette smoking as well as the inhalation of dust (DX28-57). When asked if there was a way to distinguish between the two, he testified that "usually the bronchitis from cigarette smoking is worse" (DX28-58). With

[18]The date noted in the report by Dr. Simpao when Claimant allegedly started smoking is 1989. However, Mr. Knight allegedly had his heart attack in 1986 and therefore could not have "reduced" his consumption to two or three cigarettes per day three years before he started smoking..

respect to Claimant's condition, Dr. Taylor stated that Claimant's bronchitis could be due solely to cigarette smoking, regardless of the fact that he was exposed to coal dust (DX28-59). He also testified that an individual who developed "industrial bronchitis" associated with exposure to coal dust would be expected to get better or recover completely once he was no longer exposed to the irritating dust. Dr. Taylor also stated that, based on the fact that Claimant's last coal mine employment was in 1982, the bronchitis with which he was now afflicted is, more likely than not, caused by cigarette smoking (DX28-60). Dr. Taylor further acknowledged that the first time he ever documented any association between Mr. Knight's COPD and coal dust exposure was in his April 24, 2000, letter to Claimant's attorney (DX28-61).

Jerome F. Wiot, M.D.

In a one-page letter to counsel for Peabody dated August 16, 2000, Dr. Jerome F. Wiot expressed the opinion that Claimant did not suffer from pneumoconiosis (DX28-123). This opinion was based on his review of a November 12, 1999, chest x-ray which, according to Dr. Wiot, revealed basilar linear fibrotic changes which were likely post-inflammatory and not a manifestation of coal dust exposure. In another one-page letter to counsel for Peabody dated September 12, 2000, Dr. Wiot reached a similar conclusion after reviewing the August 23, 2000, chest x-ray obtained by Dr. O'Bryan (DX28-99).

William M. O'Bryan, M.D.

At the request of Peabody, Dr. William M. O'Bryan physically examined Claimant on August 23, 2000 (DX28-104-120). A report of the examination reflects a history of coal mining employment of between 14 and 15 years and a medical history of pneumonia, attacks of wheezing, bronchial asthma, and heart disease. Prior hospitalizations for pneumonia in 1974 and a heart attack in 1987 are also listed. With respect to Claimant's history of smoking, Dr. O'Bryan noted claimant began smoking cigarettes at age 30, and smokes one pack per day. A narrative summary in the report reflects that Mr. Knight appeared 15 years older than his stated age, he did not act dyspnic, he did not cough, and he had severe varicosities. Based on the results of the examination, as well as the results a chest x-ray, a pulmonary function study, and an arterial blood gas study, Dr. O'Bryan concluded that Mr. Knight does not suffer from pneumoconiosis. He further concluded that the weight of the evidence supports a diagnosis of obstructive lung disease due to Claimant's many years of cigarette smoking (DX28-104).

Ben V. Branscomb, M.D.

At the request of Peabody, Dr. Ben V. Branscomb reviewed Mr. Knight's medical records and prepared a five-page summary of his findings and conclusions dated September 19, 2000 (DX28-74-78). Dr. Branscomb is a graduate of Duke University Medical School and is a Distinguished Professor Emeritus of the University of Alabama at Birmingham. He is Board-certified in internal and pulmonary medicine, and a certified B-reader. Dr. Branscomb's report specifically identifies the medical records he reviewed, summarizes their contents, and notes his conclusions with respect to

Claimant's medical condition. According to Dr. Branscomb, based upon his review of all the medical evidence, there is no indication Mr. Knight has contracted any pulmonary disease as a result of exposure to coal mine dust. He further concludes that Claimant does not have pneumoconiosis, and Claimant has no other pulmonary disease which has in any way been aggravated or caused by exposure to coal dust (DX28-77). Dr. Branscomb opined that Mr. Knight is not totally disabled from a respiratory standpoint, although he is fully disabled as a result of coronary and vascular disease, and any respiratory impairment Claimant has was neither caused nor aggravated by exposure to coal dust.

Gregory J. Fino, M.D.

At the request of Peabody, Dr. Gregory J. Fino prepared a ten-page report dated December 14, 2000, in which he describes his review of Claimant's medical records and the conclusions he reached as a result of that review (DX28-29-38). Dr. Fino is a graduate of the University of Pittsburgh School of Medicine, is Board-certified in internal medicine and pulmonary diseases, and is a certified B-reader. According to his report, Dr. Fino concluded that: (1) there is insufficient objective medical evidence to justify a diagnosis of pneumoconiosis; (2) Claimant does not suffer from an occupationally acquired pulmonary condition; (3) Claimant suffers from a moderate respiratory impairment secondary to smoking; (4) Claimant is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort; and (5) even assuming Claimant has pneumoconiosis, such condition has not contributed to Claimant's moderate respiratory impairment (DX28-37-38). In his discussion of how these conclusions were reached, Dr. Fino noted that the majority of Claimant's chest x-rays were negative for pneumoconiosis and the spirometric evaluations performed showed an obstructive ventilatory abnormality which had occurred in the absence of any interstitial abnormality. He further noted that Claimant's small airway flow was more reduced than his large airway flow, and that such a finding is not consistent with a coal dust related condition but is consistent with cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma . According to Dr. Fino, Claimant's medical records reveal no evidence of obstruction from fibrosis related to coal mine dust exposure. He further wrote that the clinical information available with respect to Mr. Knight's respiratory impairment is consistent with a smoking related impairment.

In evaluating medical opinions, an administrative law judge must first determine whether opinions are based on objective documentation and then consider whether the conclusions are reasonable in light of that documentation. A well-documented opinion is based on clinical findings, physical examinations, symptoms, and a patient's work history. *Fields v. Island Creek Coal Company*, 10 BLR 1-19 (1987) and *Hoffman v. B&G Construction Company*, 8 BLR 1-65 (1985). For a medical opinion to be "reasoned," the underlying documentation and data should be sufficient to support the doctor's conclusion. *Fields, supra.* In evaluating conflicting medical reports, as with x-ray analysis, it may be appropriate to give more probative weight to the most recent report. *Clark v. Karst-Robbins Coal Company*, 12 BLR 1-149 (1989)(en banc). At the same time, "recency" by itself may be an arbitrary benchmark. *Thorn v. Itmann Coal Company*, 3 F.3d 713 (4th Circuit 1993). Finally, a medical opinion may be given little weight if it is vague or equivocal. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Circuit 1995) and *Justice v. Island Creek Coal Company*, 11 BLR 1-91

(1988).

Only two medical opinions in this record favor a finding that Mr. Knight has pneumoconiosis which was either caused or aggravated by exposure to coal dust. These are the April 24, 2000, opinion of Dr. Frank Taylor (DX26), and the November 12, 1999, opinion of Dr. Valentino Simpao (DX12). I find neither opinion well reasoned and therefore accorded them little weight.

Given his long-term treatment of Claimant, Dr. Taylor is conceivably the physician who is in the best position to offer an opinion regarding whether Mr. Knight's respiratory impairment was either caused or aggravated by exposure to coal dust. *See Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989) (more weight may be accorded conclusions of treating physician who is more likely to be familiar with miner's condition than physician who examines miner episodically). He began treating Mr. Knight in June 1985 when Claimant was hospitalized for pneumonia. He sees Claimant about once every three months, and the principal reason for these visits is his treatment of Claimant's respiratory disorder (DX28-54). He is Board-certified in both internal and pulmonary medicine, and he is thus knowledgeable about respiratory and pulmonary disorders (DX28-49). He is also fully aware that Claimant worked in and around coal mines for approximately thirteen years and that Mr. Knight left that employment in 1982 (DX28-53, 57-58).

In his April 24, 2000, letter to Claimant's attorney, Dr. Taylor wrote that Mr. Knight's "exposure to coal mine dust for thirteen years in a susceptible individual is enough to aggravate an existing lung disease and I believe this happened with Mr. Knight" (DX26). The statement clearly does not indicate that Claimant's coal dust exposure *caused* his respiratory disorder, but merely suggests that his lung disease was somehow aggravated, to an unspecified degree and for an unspecified period, by coal dust exposure. Dr. Taylor's letter gives no explanation or rationale for his opinion, and I thus accord it little weight. *See, e.g., Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992 (a treating physician's report which is not well-reasoned or well documented should not be given greater weight).

When subsequently questioned about Claimant's medical condition at a September 2000 deposition, Dr. Taylor also stated that Mr. Knight "developed COPD as a result of his persistent cigarette smoking" (DX28-56). With respect to the extent to which coal dust may have aggravated Claimant's respiratory condition, Dr. Taylor testified that, since Claimant had not been exposed to coal dust since leaving coal mine employment in 1982, any symptoms or problems associated with his present respiratory impairment was more likely than not a result of cigarette smoking (DX28-60). Dr. Taylor further testified that none of the chest x-rays taken during the years of his treatment of Mr. Knight revealed any abnormalities suggestive of pneumoconiosis, and he stated that the first time he ever documented any association between Claimant's respiratory condition and exposure to coal dust was when he responded to Claimant's attorney's request in the April 24, 2000, opinion letter (DX28-61-62). In light of his deposition testimony, particularly his acknowledgment that there are no prior treatment records associating Mr. Knight's respiratory problems with coal dust exposure, I am persuaded that Dr. Taylor's opinion that Claimant's respiratory impairment was aggravated by coal dust exposure is contrary to the evidence of record.

The only other medical opinion supportive of a finding of pneumoconiosis was offered by Dr. Simpao who examined Mr. Knight on November 12, 1999 (DX12). Based on the results of his examination, which included a chest x-ray, a pulmonary function test, and an arterial blood gas study, he concluded that Claimant suffered from category 1/0 coal workers' pneumoconiosis. However, when deposed in January 2000, Dr. Simpao acknowledged that x-ray evidence of pneumoconiosis is normally seen in the upper lobes of the lungs, and he saw no such evidence in the upper lobes of Mr. Knight's lungs. Dr. Simpao further testified it was at least as likely as not that he would not have diagnosed pneumoconiosis had he not interpreted the September 1999 x-ray as positive for pneumoconiosis (DX24-10-12). Given Dr. Simpao's inability to provide a rational basis for his diagnosis when the x-ray upon which he relied did not reveal abnormalities in Claimant's upper lungs consistent with pneumoconiosis, I find his opinion is not well reasoned and accord it little weight.

The remaining medical opinions in this case support a conclusion that Claimant does not suffer from pneumoconiosis. For example, Dr. Fino concluded that Mr. Knight had not contracted any pulmonary condition as a result of exposure to coal dust (DX28-37-38). He has substantial experience in the field of pulmonary medicine and has been certified as a B-reader since 1989 (DX28-41). Furthermore, he reached his conclusions after reviewing all the medical evidence of record available at the time of his opinion (DX28-29-38, 74-78). Similarly, Dr. Branscomb concluded that Mr. Knight had not contracted any pulmonary condition as a result of exposure to coal dust (DX28-77). Like Dr. Fino, Dr. Branscomb reached his conclusions only after reviewing all medical evidence that was then available.[19] He has a long and distinguished career as both a practitioner and professor of pulmonary medicine, and he has written extensively on a variety of topics including: pulmonary function testing; the respiratory system; respiratory diseases; circulatory disorders of the lung; the care of patients with chronic obstructive lung disease; and criteria for diagnosing coal worker's pneumoconiosis (DX28-80-89, 90-97). Dr. William O'Bryan, like Drs. Fino and Branscomb, also concluded that Mr. Knight does not have pneumoconiosis. He is Board-certified in both internal and pulmonary medicine and was previously certified as a B-reader from 1994 to 1998. His opinion is based on an examination of Claimant on August 23, 2000, and his findings are supported by other substantial evidence of record.[20]

In determining that these physicians' opinions are entitled to great weight, I recognize that they do not take into account the positive chest x-rays taken April 16, 2001, and April 25, 2002 (CX2, CX3). However, there are several reasons which support my decision to accord them greater weight than the contrary evidence. First, x-ray evidence is never conclusive with respect to diagnosing pneumoconiosis. Indeed, there are many other medical conditions which can result in

[19]With regard to Dr. Taylor's opinion that Claimant's respiratory impairment was "aggravated" by coal dust exposure, Dr. Branscomb also notes that Dr. Taylor's records contain no medical justification for such a conclusion (DX28-76).

[20]Dr. Jerome Wiot, who is a Professor of Radiology and certified as a B-reader, also offered an opinion with regard to whether Mr. Knight suffered from pneumoconiosis. After reviewing Claimant's November 12, 1999 and September 12, 2000, chest x-rays, he concluded that there was no evidence of coal workers' pneumoconiosis (DX28-99, 123). Dr. Wiot's conclusions are consistent with the majority of the other medical opinions of record.

changes observable on an x-ray similar to those seen in cases of coal workers' pneumoconiosis (DX24-10). Examples of such conditions include pulmonary emboli, pneumonia, asthma, and COPD, all of which have been previously diagnosed in Mr. Knight (DX28-76-77). Thus it is entirely possible that the x-ray changes interpreted by Dr. Brandon as evidence of pneumoconiosis are in fact changes caused by one or more of Claimant's previously documented medical conditions. There is nothing in the record to suggest that Dr. Brandon ever reviewed any medical evidence regarding Mr. Knight's medical condition other than the April 2001 and April 2002 x-rays, or that he was even aware that Claimant suffered from a variety of medical conditions which might have caused changes such as those observed on these two chest x-rays. There is thus no way to know whether Dr. Brandon's opinion might have changed had he seen this evidence. In addition, Claimant's April 2001 and April 2002 chest x-rays were read by Dr. Brandon as demonstrating only "category 1/0" pneumoconiosis which, as noted previously, is the lowest possible rating consistent with a positive finding for that condition. Such a classification connotes a certain lack of definiteness by the reader in that it indicates he seriously considered a finding that the x-ray was negative for pneumoconiosis. I therefore give less weight to these two x-ray interpretations than to the well reasoned opinions discussed above which conclude that Claimant does not have pneumoconiosis.

CONCLUSION

I find that the Claimant has not established the existence of pneumoconiosis by a preponderance of the evidence. Accordingly, Mr. Knight's claim for benefits is denied.

ATTORNEY'S FEE

The award of an attorney's fee is permitted only in cases in which the Claimant is found to be entitled to benefits. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for legal services rendered in pursuit of the claim.

ORDER

The claim of Herman D. Knight for benefits under the Act is denied.

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STEPHEN L. PURCELL
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this

Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision if filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.